

A Brief History of the Oregon Health Plan and its Features

by Richard Conviser, Ph.D.

Between 1989 and 1995, several pieces of legislation were passed in the Oregon state legislature that set into a motion a series of public and private health insurance reforms. Known as the Oregon Health Plan, these reforms were initially intended to provide access to affordable health insurance for all state residents. The Plan has three main components: (1) extending Medicaid eligibility to all state residents with incomes below the federal poverty level (FPL), (2) establishing a High Risk Insurance Pool for people refused health coverage because of pre-existing medical conditions, and (3) providing small businesses with a broader range of insurance options and their employees with a better ability to retain their health insurance when changing jobs.

A fourth component of the Plan passed in 1989 by the legislature, mandating that employers either provide health insurance coverage for their employees or make payments into a state insurance fund, was to have taken effect beginning in 1994. However, the 1991 legislative session deferred its effective date to 1995, and the 1993 legislative session deferred it to 1997 (for businesses with 26 or more employees) and 1998 (for those with 25 or fewer). But enabling legislation that would have been required for this part of the Plan to take effect was not passed by the Congress of the United States by the beginning of 1996. Under the terms of the bills passed by Oregon's legislature, this means that the employer mandate will not take effect.

The Medicaid portion of the Oregon Health Plan went into effect in February, 1994 and enrolled nearly 120,000 new members in its first year—roughly the total number of newly insured individuals expected throughout the five-year lifespan of this demonstration program. The High Risk Insurance Pool provides benefits similar to those offered Medicaid recipients. With premiums limited to 150% of private insurance rates (due to decline to 125% in October, 1996) and all health insurers doing business in the state required to participate in funding the program, the Pool now insures more than 4,300 state

residents. To make health insurance available to people working for small businesses, a state Insurance Pool Governing Board was established in 1987 and began making insurance available in 1989. Currently it provides coverage to 27,000 people working for nearly 9,000 small businesses. Another set of insurance reforms targeted at small employers took effect in 1993, with revisions to become operational in October, 1996.

Origins

The Oregon Health Plan was launched during the 1989 legislative session by a coalition that included consumers and representatives of health care providers, insurers, business, and labor. The reform was motivated in part by a legislative committee's decision two years earlier to discontinue Medicaid coverage for organ transplants, whose costs were running twice as high as estimates. In the wake of the decision to discontinue organ transplant coverage, there was a highly publicized fund-raising attempt by the parents of a child denied public coverage for a transplant. The child died before their attempt could succeed. At the next session of the state legislature, the physician/Senate president, John Kitzhaber (now Governor of Oregon), helped to persuade his legislative colleagues to undertake a fundamental reform of the state's health care system rather than reconsider the organ transplant issue alone. Bills providing for the main components of the Oregon Health Plan passed the legislature (which meets in regular session only in odd-numbered years) in 1989.

A central tenet of the Plan is that eligibility for health care coverage can be expanded if cost-containment mechanisms are built into the system. The Oregon Health Plan has two such mechanisms: managed care and benefit limitations. Most new recipients of Medicaid coverage in Oregon must choose among the health maintenance organizations (HMOs) contracting with Medicaid in their county of residence. (The remaining $\frac{1}{4}$ of the state's Medicaid enrollees, most of them elderly or disabled, are able to receive services on the more traditional fee-for-service basis.) The state pays the HMOs flat monthly per client fees in four rate categories to provide coverage; clients must obtain a referral from their

primary care physicians for specialist and hospital care. Reimbursement for hospital care was taken into account in the capitation rate on the basis of diagnosis-related groups (DRGs), a methodology initially developed by the federal government for Medicare reimbursement that typically pays fixed amounts for the care of particular conditions. However, hospitals are free to contract with HMOs for reimbursement on a DRG, capitated, per diem, or fee-for-service basis. While managed care has its critics, it is the benefit limitations of the Oregon Health Plan—sometimes regarded as a scheme to ration care—that have drawn the most critical attention.

Oregon's Prioritized List of Services

The legislation establishing the Plan called for the formation of an eleven-member Health Services Commission. Consisting of consumers and providers of health and social services, the Commission was charged with ranking health care services for coverage “according to their benefit to the entire population being served.” Coverage was to be provided for all conditions above a threshold on the prioritized list, with the threshold being set each session by the state legislature on the basis of actuarial estimates and budgetary constraints. To arrive at a preliminary version of the prioritized list of services, the Commission adopted a cost-benefit methodology that ranked conditions and treatments according to four factors: their cost, the net duration of benefit, physician estimates of the likelihood that treatment could alleviate symptoms or prevent death, and citizen views on the seriousness of symptoms and functional limitations. More than fifty physician panels met to develop estimates. Citizen values were obtained through both a telephone poll of 1,001 state residents and a series of community meetings and hearings organized by Oregon Health Decisions, a community service organization dedicated to obtaining citizen input on ethical issues in health care.

The preliminary version of the prioritized list was widely criticized for producing counterintuitive rankings; tooth capping, for example, was ranked above an appendectomy. Rather than refining the methodology of the cost-benefit approach, however, the

Commission elected to base its next prioritized list primarily upon citizen values that were articulated at the community meetings, giving high ranks to such areas as preventive and maternity care. Certain types of benefits mandated of state Medicaid programs by the federal government fell below the proposed coverage threshold on Oregon's prioritized list. Also, Oregon proposed extending Medicaid eligibility beyond the categories allowed by federal law. Consequently, the state was required to apply to the federal Health Care Financing Administration (HCFA) for a Medicaid waiver. Oregon submitted its first application late in 1991; the federal government denied the application in 1992, claiming that the prioritized list violated the Americans with Disabilities Act (ADA) because it was based in part on the importance that healthy citizens assigned to health states experienced by people with disabilities.

In consultation with federal officials, Oregon's Health Services Commission responded to the waiver rejection by once again revising the methodology for the list. Its next version placed primary emphasis on the ability of treatment to prevent death and relieve symptoms and on costs, with adjustments made in accordance with perceived citizen values (e.g., raising the rank of preventive care). The federal government approved Oregon's Medicaid waiver but required that the list be stripped of references to symptomatic relief, again held to be in violation of the ADA. The list with which the Commission responded ranks treatments directly according to their ability to prevent death and inversely according to their cost. The Commission once again made adjustments to the list by, for example, clustering similar conditions together and ranking treatment that prevents a condition above treatment for the condition. This list formed the basis for Medicaid coverage in Oregon. It contains 745 items, and from the Plan's effective date until the end of 1995, Medicaid coverage was provided for the first 606 of them. In addition to the services above the list threshold, Medicaid provides coverage for medically appropriate diagnostic procedures.

Consequences of the Plan's Adoption

The most immediate result of Oregon's reform effort was that many residents who previously had no health insurance gained such coverage. (As many as 180,000 additional state residents may ultimately qualify for Medicaid coverage under the Oregon Health Plan.) It was expected that they would avail themselves of effective low-cost care early in the course of illnesses rather than going to emergency rooms later, with more serious and less treatable conditions. As evidence that this strategy has been working, the Oregon Association of Hospitals and Health Systems (OAHHS)—a strong advocate of the Plan—reports that hospital emergency room (ER) visits in the state declined by 5.3% in 1994 relative to 1993 and that urgent care clinic visits were down by 1%. More recent OAHHS reports show that the number of ER visits continued to decline in 1995, falling by 2.1% statewide (and 6.2% in rural areas) during the first seven months of the year relative to the comparable period of 1994.

By increasing the number of people with coverage, the Medicaid portion of the Plan was also expected to decrease the need for charity care and for cost-shifting to people with private insurance. OAHHS reports that in 1994, charity care at state hospitals declined by 18.7% relative to the previous year and bad debts, by 10.6%. In the Portland metropolitan area, these reductions were even greater—23.8% and 15.7%, respectively. Charity care admissions continued to decline in 1995; for the first seven months of the year they were down 32.5% relative to the same period of the previous year, and bad debts were down 8.5% (20.1% in rural areas). The reductions were achieved despite the fact that Medicaid no longer provides automatic reimbursement for emergency room visits (since clients are expected to consult with their primary care physicians first), although many HMOs do pay triage fees to ERs. The Medicaid reform has also been credited with a decline in the number of Oregonians receiving Aid to Families with Dependent Children (AFDC). It is believed that the availability of Medicaid coverage for those with incomes below the FPL

has permitted some people to give up welfare, allowing them to take low-paying jobs that do not offer health insurance as a benefit.

The incentives put in place in 1993 to increase private health insurance coverage among employees of Oregon's small businesses have had only modest effects. However, reforms taking effect in the last quarter of 1996 are likely to have more noticeable consequences. These reforms will require all health insurers doing business in the state to make the same insurance plans available to small employers that they offer to larger employers, with rate adjustments being permitted only on the basis of the ages of the insured. For three years, the allowable variation in premiums on this basis will be only $\pm 50\%$ from the average premium charged by a carrier. The rate band will then be reduced to allow variations of only $\pm 33.3\%$. Several other features of the small business reforms will make it easier for employees to obtain and maintain health insurance coverage. Employees will be able to be excluded from coverage on the basis of pre-existing conditions for only six months, and if they change jobs, they will not be subject to a similar exclusion again. Employees leaving self-insured firms will be able to purchase continuing health insurance coverage through the High Risk pool at premiums comparable to those charged in the insurance market in general. These employees will also be given a choice between the sort of coverage they previously had and a lower-cost, more basic plan. Thus, people changing jobs or leaving the job market will be able to extend their health coverage indefinitely, in contrast with the 18-27 months allowed under federal COBRA legislation.

The employer mandate portion of the Oregon Health Plan had several narrow scrapes before it was finally invalidated. The mandate was initially intended to take effect in 1995, but legislation passed in 1993 delayed its effective date to 1997 or 1998 (depending on the number of workers employed by a business). A bill passed in Oregon's 1995 legislative session called for the abolition of the employer mandate, but the governor vetoed the bill. Nonetheless, enactment of the employer mandate was dependent on the granting of a federal waiver. This waiver was necessary to relieve the requirements of the Employee

Retirement Income Security Act (ERISA), a federal law passed in 1974 that prohibits states from enacting laws or regulations relating to employee benefit did not pass a bill by January 1, 1996 granting the ERISA waiver; hence, under a sunset provision in Oregon's legislation, the employer mandate died. This loss provided a blow to Oregon's dream of providing universal health coverage. Especially now that the Medicaid portion of the Plan is in effect, the vast majority of the state's more than 400,000 uninsured people (about 13% of the state's population) are the working poor.

Changes in the Plan

The 1995 legislature directed the state Medicaid agency to implement a number of changes designed to reduce the cost of the program; these had all taken effect by the beginning of 1996. Instead of documenting just one month's income below the FPL to qualify for six months of coverage, applicants have to show that their average income for three months has been below the FPL (in 1995, this was \$1049/month for a family of three). Full-time college students are no longer eligible for the Plan, and all applicants are limited to \$5000 in liquid assets. For people eligible for Medicaid only as a result of the Oregon Health Plan, monthly premiums have been instituted on a sliding scale ranging from \$5 to \$26 per month. Mental health services were included in the prioritized list beginning in 1995, with 25% of the state's Medicaid recipients (those in selected counties) obtaining those services through managed mental health contracts. The managed mental health delivery system was to be extended to all Medicaid recipients by 1996; however, the legislature decided to postpone the extension, leaving its date of enactment unspecified. Finally, the legislature instructed the state to apply for a federal waiver to raise the covered benefits threshold under the prioritized list by 25 lines (to line 581 out of 744) to hold constant per capita monthly costs. Such a change is not expected to have serious consequences for the vast majority of Medicaid recipients; treatments linked with the conditions ranked nearest to the bottom of the prioritized list are the least effective.